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STATEMENT

of the

Medical Group Management Association

to the

Committee on the Budget

U.S. House of Representatives

MEDICARE: The Need for Regulatory Relief

Gary S. Kaplan, MD, CMPE

Chair, Board of Directors

Medical Group Management Association

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Good morning. My name is Gary Kaplan, MD. I am the Chair of the Board of the Medical Group Management Association. On behalf of MGMA, I would like to thank the Chairman, the ranking member, and the entire Committee for convening today's hearing. I also would like to extend our gratitude to the Committee for its leadership in pursuing information on the costs and administrative burdens that the Medicare program imposes on both providers and the government.

The hearings held by this Committee during the 106th Congress focused the attention of members of Congress and the new Administration on numerous administrative barriers affecting the delivery of care to Medicare beneficiaries. The foresight of this Committee resulted in a GAO study measuring Medicare's paperwork burdens in which MGMA members participated. This study and other efforts by the Committee led to policy makers actively discussing solutions to these problems.

MGMA is the nation's oldest and largest medical group practice organization representing more than 18,000 administrators working in organizations in which over 176,000 physicians practice medicine. MGMA's membership reflects the full diversity of physician organizational structures today. Our members work on a daily basis ensuring their practices provide the best care possible to Medicare beneficiaries, while at the same time navigating their medical groups through a sea of complex, and often contradictory rules, regulations, and policy memoranda. As a result, MGMA is uniquely familiar with the administrative requirements of Medicare's regulations.

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In addition to my leadership position with MGMA, I am a practicing internist and the Chairman and CEO of the Virginia Mason Medical Center, an integrated, non-profit medical center with 400 physicians and over 5000 employees. These health care professionals serve together in a multi-specialty group practice in Western Washington State with 13 clinic sites and a 330-bed hospital. Virginia Mason hosts a thriving graduate medical education program, a prominent research center, and serves as a referral center for the entire Pacific Northwest.

As the Chair and CEO of Virginia Mason I am charged with many diverse responsibilities. The physicians in our practice rely on me and my administrative staff to guide them through the remarkable complexities of today's health care delivery system. They require our business "know how" to allow them focus on the importance of their day-to-day clinical interaction with their patients. As the leader of an organization that honors strong commitment to quality and integrity, I am responsible for ensuring that each of our physicians, administrators and staff understand and abide by the rules that govern our work. Too much time is spent by practice personnel dealing with the innumerable and continually changing federal rules and regulations governing coding, documentation, billing, physician referral rules, Local Medicare Review Policies, physician credentialing and the assignment and reassignment of patient and physician billing rights, at the expense of patient care.

I have experienced, on a personal level, the growing frustration of most managers and administrators with the ever-increasing mass and complexity of federal regulations. The varied level of communication, organization, and responsiveness from CMS and its contractors makes efforts to understand, much less comply with these rules, all the more difficult. Regulations such as the recently released privacy rule create a gold mine for attorneys and consultants, but an administrative landmine for our medical group practices.

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My comments today will focus on the administrative ills of the Medicare program and how these problems lead to federal government and medical group practice management inefficiencies, unnecessarily diverting limited resources away from patient care. While MGMA agrees with both the current and previous Administrations that additional CMS funding is warranted, the efficiencies resulting from improving CMS's organization, communication and responsiveness will vastly improve the system without creating additional costs.

Examples of Breakdowns:

Let me begin with actual examples of burdens and breakdowns in the administration of Medicare. I will begin my discussion with two examples of problems we have personally had with the administration of the Medicare program, followed by those experienced by my colleagues nationwide. Through these examples, I hope to give you some insight into medical group practice management and the constant battles we wage with inefficiencies in the Medicare system. As you continue your oversight of this program and develop recommendations for improvements, I urge you to personally visit a group practice in your district and discuss Medicare's complexities with the practice administrator.

Inflexible Requirements and Senseless Use of Resources

In certain circumstances Medicare requires providers to determine whether Medicare or another payor will be the primary source of payment for the services provided. The fiscal intermediaries (FI) are responsible for occasional routine reviews to assure that a provider is collecting the proper documentation from hospital patients.

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Our FI notified us of a routine audit earlier this year. However, in a glaring example of a good thing taken to an inefficient extreme, the FI requested copies of specific documents for each service billed to Medicare for one entire month. The FI indicated that they would select, at random, only 60 encounters from the entire collection documents for use in their audit.

We informed the FI representative that the request would involve many thousands of patient visits and claims, and would require a dramatic, time-consuming effort to produce. This work seemed neither necessary nor cost efficient given their ultimate need for just 60 items. We were informed that these were the audit guidelines, and that we were to produce the documents as requested.

Over the next five weeks, Virginia Mason personnel from the Director of Operations to temporary staff (hired specifically for this audit) put in 1,019 hours and used twelve boxes of copier paper to collect, print, and copy the requested documents. By the day of the audit, 33 boxes containing information for 17,000 patients and 43,000 claims had been collected.

As promised, upon arrival the auditor quickly chose documents representing 60 claims at random from the roomful of boxes. The auditor reviewed the documents quickly then left, having spent 2.5 hours on site. We were left with over 60,000 documents to refile or destroy. We understand that the auditor was simply following established audit guidelines. We believe, however, that there are more effective means of addressing Medicare's well-intentioned audit concerns.

Complexity and Lack of Coherence in Rule Presentation

Medicare requires that physicians provide patients with an Advance Beneficiary Notice (ABN) of non-covered services. This well-intentioned requirement was designed to give a

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patient better knowledge of their coverage and potential out of pocket costs before accepting a particular service.

However, the situations in which providers must provide an ABN are not easily understood, varying from code to code. Further, these rules are not set out in a central location in CMS rules or carrier guidelines, but are instead strewn through out various manuals and guidebooks.

Recognizing the daunting task these rules posed to physicians and staff wanting to provide ABNs at the appropriate times, Virginia Mason was forced to accumulate and organize the rules itself into an internal manual. After over 300 person-hours of long and largely duplicative work, the manual was a remarkable 188 pages in length. Because each page must be reviewed for accuracy whenever any governing authority releases a revised or new policy, the work of updating the manual is never done.

We appreciate and applaud CMS' recent efforts to design a simpler, more patient-friendly model ABN form. However, we now ask for similar help in formulating simple, provider-friendly rules that govern when to use them.

Inconsistencies in Coverage Rules Without Notice

We also encounter inconsistencies between local coverage rules and a carrier's implementation of those rules. Often policy changes are made without notice to the provider. As an example, Local Medicare Review Policies (LMRPs) for the state of Washington do not designate coverage limitations for spirometry services (measurements of lung volume and air flow). However, our detailed review of Medicare denials discovered that these claims were routinely being denied as non-covered services.

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After a time consuming investigation, we found that while Washington State LMRPs do not limit coverage for spirometry, other states within our Part B Carrier's area do. The Carrier had simply adopted these other states' standards and applied them to its entire area, effectively trumping our local LMRPs. This decision was made without creation of a formal policy and notice to providers. If it were not for our detailed denial review and extensive investigation these claims would have continued to be denied for completely unknown reasons.

As a result of our efforts in this area we understand that a carrier-wide spirometry policy is now being drafted, and we applaud the carrier's responsiveness to our concerns. However, we feel providers should not shoulder the burden of discovering such inconsistencies through denial reports.

Carrier Changes to Coding Guidelines Without Notice or Explanation

Under current coding guidelines (Current Procedural Terminology-4, or CPT-4), if a physician performs two related procedures for a patient on the same day, one of the procedures will be paid at only 50% of the regular allowed amount, since the costs involved are presumed to be lower for the second procedure. In billing language, the guidelines require a -51 modifier to be attached to the second procedure code.

The CPT manuals clearly indicate certain exceptions to this rule, however, including diagnostic cardiac catheter procedures. Thus, under CPT guidelines no modifier must be attached for these procedures, and full payment is indicated.

However, despite this CPT guideline, our Carrier has determined -- without prior explanation or notice -- that the above rule will indeed apply to diagnostic cardiac catheter procedures in its coverage area. It therefore processes the claims accordingly, and imposes the 50% payment reduction. The carefully constructed and extensively used CPT manuals should

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not be arbitrarily reversed through Carrier discretion without a clear explanation and well published notice to those affected. And again, providers should not need to discover these rules through their after-the-fact denial reports.

Carrier Systems Issues

Our Medicare carrier credentials physicians for both their specialty and any appropriate subspecialties. A physician may therefore be credentialed not only for internal medicine, but also for a subspecialty in pulmonology. However, the carrier's claims processing system is able to receive only one of these data fields through its interface with the credentialing system, essentially ignoring any information on subspecialty.

Under Medicare rules, only one physician visit from the same specialty may be charged in a single day. In complex cases, however, patients will frequently be seen by both an internal medicine physician who is coordinating the patients' care, and a second internist with a subspecialty in pulmonology. Because of the carrier's system limitations, the subspecialty of the second physician is ignored, and the pulmonologist's claim is simply denied as unnecessary.

We recognize that this is a systems problem and are grateful for the carrier's intentions to upgrade its claims processing systems to address the issue. However, we spend tremendous time and effort in addressing these particular denials each day. Practices should not be forced to bear the burdens of correcting problems caused by inadequate carrier systems.

Lack of communication from CMS to Contractors and in turn to Providers as well as Ineffective Routine System Changes

On October 30, 2000, CMS sent carriers an electronic quarterly update of the Correct Coding Initiative (CCI). The CCI contains more than 121,000 pairs of codes that cannot be billed on the same claim to Medicare. Each quarter it is "updated" to add or delete various code

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combinations. Under CCI, claims are scanned and scrubbed electronically for “disallowed” code pairs, which are then automatically denied.

Without any prior notice to providers or carriers as to its contents, the October version of the CCI disallowed the billing of sixty-six different evaluation and management (E&M) codes when performed on the same day as over 800 procedures. Providers were never told that as a result of this revision, in order to bill for a physician visit or other E&M code on the same day as any one of the 800+ procedures, they were required to use the “-25” billing “modifier” or annotation. Implementation of the CCI update resulted in thousands of claim denials. However, many carriers did not become aware of the cause of the denials until the provider community notified them of the problem. The carriers simply implemented the electronic edits received from CMS without knowing how the action would affect their claims processing operation. To further exacerbate the situation, carriers denied claims that actually used the correct modifier. In a memo sent out to the provider community outlining the problem in late January, CMS admitted that, “Unfortunately, a number of carrier processing systems do not recognize the -25 modifier” with certain codes.

While parts of the October update were rescinded on February 8, 2001, the original implementation occurred at tremendous cost to both providers and carriers. Not only did this communication breakdown between CMS, the carriers and ultimately providers, result in physician practices around the country having to resubmit thousands of denied claims billed from October 30, 2000 to February 8, 2001, it undermined the trust and credibility necessary to preserve a good working relationship between practices and carriers. As a side note, members of the Committee might be interested to know that if my, or any other practice, as a participating provider in the Medicare program, desires access to a copy of the quarterly CCI update, it is not

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accessible online and only available through NTIS Products (CMS's authorized distributor) for an annual \$300, four issue, subscription fee or \$85 per single update, plus shipping and handling.

Inconsistencies between CMS manuals and Medicare Statute

Frequently, the relationship between providers, carriers and CMS is strained due to the ambiguous and, at times, incorrect information in the Medicare Carriers Manual itself. The Medicare Carriers Manual contains CMS's instructions to its carriers on how to administer the program. The following technical, yet illustrative example shines light on one such example of this problem. Under 1861(s)(3) of the Social Security Act, "diagnostic x-rays, diagnostic laboratory services and other diagnostic tests" are covered separately by Medicare from physician services. However, section 2070 of the Medicare Carriers Manual states "for diagnostic X-ray services and other diagnostic tests, payment may be made only if the services are furnished by a physician or incident-to a physician service (which requires direct-supervision by the ordering physician). This carrier manual provision is contrary to the Social Security Act Section 1861(s)(3) coverage provisions for these services and has caused numerous interpretive problems between providers and carriers concerning the appropriate level of physician involvement and supervision.

Lack of Notice to Medical Group Practices of CMS' Intentions to Change Billing and Payment Rules

Medical group practices trying to play by the rules are often blindsided by policies implemented without notice to or input from the effected parties. For example, in May of 1998, CMS issued Transmittal No. 1606, which drastically changed the billing rules for allergy

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immunotherapy. The new rule, which amended the definition of "dose," meant that physicians could, in most situations, only bill for half as many doses as they had actually prepared. CMS's interpretation went against longstanding practice and was inconsistent with the CPT Code definition and the American Medical Association's CPT guidance. This change took effect without prior notice to the physician community. The effect of the adjustment reduced reimbursement in half for allergy immunotherapy billed under CPT Code 95165. It took the affected physician practices and their representatives two and a half years to get CMS to see the error of its policy. The policy was finally rescinded effective January 1, 2001 with the implementation of the 2001 Medicare physician fee schedule.

Carrier Mistakes Unresolved

While some Medicare carriers and intermediaries are quite good, others are plagued with problems that may take months to resolve. Prompt action by Medicare carriers and intermediaries to resolve their own mistakes is critical to the Medicare program. The following example from a colleague of mine illustrates this point.

In September 1999, a large multi-site practice organized as a rural health clinic, located in Michigan, received Medicare checks totaling \$1,260,184.84, far in excess of their billed charges. The management service organization (MSO) that does billing for these clinics, immediately notified United Government Services, LLC, (UGS) their Medicare fiscal intermediary, about this overpayment and were told that the intermediary would get back to them on the issue. The MSO asked if they could return the checks but UGS instructed them to retain the payment until the problem had been sorted out. The MSO contacted the intermediary once a week for a month before they were told that there had been a problem with UGS' processing system that had

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produced this overpayment. UGS' Detroit office instructed the MSO to retain the money and that it would be recouped via withholdings from future payments. The MSO informed the Medicare intermediary that recouping the money in this way would take a minimum of five years. UGS' response was that the same type of erroneous payments had been sent to a number of other physicians. These incorrect payments were direct deposited to the physicians' accounts and as a result the physicians were drawing interest on the money. The clinic's payment had been sent in the form of a paper check and UGS felt that the clinic should have the same opportunity to draw interest on these incorrectly paid funds. The clinic did not want to cash the payments in the first place.

To resolve this problem the MSO spent an extensive amount of time attempting to obtain corrected explanations of benefits so that they could ascertain what the correct payment should have been and then return the difference. This process took months and involved a great deal of back and forth between the MSO and the Medicare FI. Finally, on September 21, 2000, more than a year after the initial overpayment by the fiscal intermediary, these problems appeared resolved and the overpayment was returned to UGS the Medicare intermediary.

The problem, however, was not resolved at this point. During the year in which the clinic and its MSO billing entity had been attempting to sort out the problem, UGS, the intermediary had, as they originally proposed, been withholding Medicare payments due to the clinic to make up for their original erroneous overpayment. When the MSO returned the overpayment, UGS *continued* to withhold payment for current claims. Efforts by the clinic to resolve this problem were unsuccessful until the HCFA Regional Office was contacted to assist the clinic in its dealings with the intermediary.

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Lack of CMS Oversight and Enforcement of its Requirements Over Contractors

The Medicare Carriers Manual, under Section 1030.1 (enrollment instructions to the carriers) states "absent extenuating circumstances, [a carrier must] process an application for non-certified providers within 45 calendar days of receipt of the application. For certified providers, process the application within 30 calendar days, absent extenuating circumstances. If you need to review the application for incomplete or missing information, the processing time stops. Complete the review of the application and annotate what information is missing prior to returning application (emphasis added)." In reality, this is not what occurs. If a carrier finds an error in the application, it sends it back to the provider at the first instance of an error taking place. Once corrected by the provider, the application goes to the "back of the line" to begin the process anew. Due to the complexity of the 34-page application and instructions, this resubmission process sometimes may occur several times before a physician is enrolled in the program. If a review was actually done in a complete manner as per the Medicare Carrier Manual, and the information annotated in its entirety, before being returned to the provider for correction, the process would work much more efficiently. Instead, it now may take up to 6 months to enroll a physician in the program. During this time period, a physician can examine and treat Medicare patients, but all claims resulting from those services cannot be submitted for payment until the certification process is complete. Situations like this are particularly aggravating given that the physician enrollment process has no statutory foundation in the Medicare Act and CMS has spent years trying to develop regulations governing the enrollment process.

Lack of Provider Education Tools and Recent Action in the Wrong Direction

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Education of providers concerning how to comply with rules and regulations is fundamental to the efficient administration of the Medicare program. I know of few, if any, physician practice managers who also happen to be lawyers. What is needed in the Medicare program are written materials and other unambiguous communications that explain the rules and regulations in a clear and concise manner. It is distressing to see directives from CMS to its carriers that impede the system's delivery of such necessary tools to its participating Medicare providers. For example in a January 25, 2001 Program memo (AB-01-12), from CMS to its carriers, CMS permits its carriers to charge a fee to providers for "reference manuals, guides, workbooks, and other resource materials developed by the contractor designed to supplement or provide easy reference to formal Medicare provider/supplier manual and instructions." For practice managers, the idea that we may now have to pay carriers a fee for access to simplified and reasonable reference materials is difficult to understand. At a minimum, this type of guidance is clearly the wrong direction to take in providing proper education and communication between providers, CMS and the carriers.

Proposed Solutions

There are many more examples such as these that I could share. The system is in dire need of change. But, instead, let me turn to solutions. While these are far from exhaustive, attending to the following would provide necessary first steps toward healing this ailing program.

- Congress should require the Secretary of Health and Human Services (HHS) to publish in the Federal Register, on no less than a quarterly basis, a notice of availability of all proposed policy and operational changes which may affect providers and suppliers including but not limited to changes to be issued through amendments to its carriers

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manuals and other CMS manuals, or program memoranda, program transmittals or operational policy letters, and of all such policy and operational changes issued in final form during the previous quarter. Simultaneous with publication in the Federal Register, the Secretary should transmit such proposed and final policy and operational changes to its Medicare contractors. The Secretary should require that its contractors notify all providers and suppliers in their service areas of such changes within 30 days of this Federal Register notice. The Secretary should further provide that any changes issued in final form will take effect no earlier than 45 days from the date such final change was noticed in the Federal Register. The Secretary should not make a change in policy or operations that affects providers and suppliers without going through the public notice process unless such change is required to meet a statutory deadline or is otherwise required by law. In that event, the Secretary must publish such change in the Federal Register along with the Secretary's justification for issuing such change in a manner other than that required.

- Congress should require the Secretary of HHS to create and distribute a user-friendly manual that contains all the information necessary for Medicare compliance. The manual should be organized, accessible (including on-line), free and up-dated quarterly. It should contain, in addition to actual regulations and program memorandum, etc., a summary of each issue, Q&A and other explanatory/supplemental material. I would be remiss not to note that as part of its small group compliance guidelines, the Office of Inspector General suggested that small groups create such a document on their own. Can you imagine, if HHS has not even accomplished this task with its many

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employees, how small medical group practices with few support staff could accomplish such a feat?

- Congress should require the Secretary of HHS to develop a site on the Internet, similar to what HHS has already developed for the Health Insurance Portability and Accountability Act section of their Web site, where Medicare providers and suppliers can post questions and obtain feedback. Responses should be maintained on the Internet site for reference.
- Congress should require the Secretary of HHS to furnish all education and training materials and other resources and services free of charge for providers, eliminating all user fees. The education materials should be drafted in easily understandable language with contact information should questions arise. The materials should be free and accessible on-line.
- Congress should require the Secretary of HHS to make every effort to educate not only the provider community but also its own staff and those of its contractors.
- Congress should instruct HHS to provide better oversight of its contractors to ensure uniform application of national policies and efficient administration of the Medicare program.
- Congress should require the Secretary of HHS to enhance and make public its contractor evaluations. The report should include all components of training, education, auditing and payment. Medicare providers and suppliers should be granted a formal process to provide feedback on the evaluation directly to CMS.

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- Congress should require the Secretary of HHS to annually conduct a review of, and report to Congress on, the sources of complexity in the Medicare program as is required of the Internal Revenue Service in Section 4022 of the IRS Restructuring and Reform Act of 1998.
- Congress should provide the Secretary of HHS with the resources necessary to adequately manage the Medicare program without provider user fees.

On behalf of the Medical Group Management Association, I thank you very much for the opportunity to share our thoughts with you today. MGMA realizes that both CMS and its contractors are called upon to accomplish an extremely difficult and complex task. MGMA members and staff are available as resources as you examine and address this critical issue.